3 Vision Guidelines

3.1 Introduction

3.1.1 General Policy

This section covers all Medicaid vision services provided through Opticians, Optometrists, and Ophthalmologists as deemed appropriate by the Department of Health and Welfare (DHW). These specialties are identified as vision services throughout this section.

3.1.2 Participant Eligibility

Providers must always check eligibility on the date of service. Participants who are covered under a restricted program do not have vision benefits under Medicaid fee-for-service. These programs include, but are not limited to, the following:

- Ineligible Aliens.
- Presumptive Eligibility (PE).
- Qualified Medicare Beneficiary Program only, without another unrestricted Medicaid eligibility program open.
- Medicare Medicaid Coordinated Plan (MMCP).
- Lock-in for emergency services only.

Limited Vision Benefits: Low-Income Pregnant Woman Program (PW)

Pregnant women who are eligible through the PW Program are only eligible for pregnancy-related services. Routine eye exams, glasses, and contact lenses are not covered for women on the PW Program.

Medical evaluation and management visits to an ophthalmologist are covered if:

- The need for services is a direct result of or caused by the pregnancy, or
- The services if not rendered, **could** adversely affect the outcome of the pregnancy for mother and/or baby.

3.1.3 Reimbursement

Medicaid reimburses vision services on a fee-for-service basis. Usual and customary fees are paid up to the Medicaid maximum allowance.

3.1.4 Medicare Crossovers for Vision Services

When a Medicaid participant also has Medicare, providers must bill Medicare before a claim is submitted to Medicaid. In most cases, Medicare claims automatically cross over to Medicaid for payment.

If the claim does not cross over, bill electronically with the proper documentation or submit a CMS-1500 paper claim form and attach a copy of the Medicare Remittance Notice (MRN). Medicaid will pay at a maximum the difference between the Medicare payment and the Medicaid allowed amount or the Medicare co-insurance and/or deductible, whichever is less. Medicare covered and non-covered services should be billed on separate claim forms.

QMB Only: Participants that have Qualified Medicare Beneficiary (QMB) coverage only, are not eligible for any Medicaid benefits. Medicaid does not provide exams, glasses, or contacts for participants with only QMB coverage. Medicaid Automated Voice Information System (MAVIS) eligibility verification identifies QMB-only participants with this comment: "*Benefits are Restricted to Medicare Paid Services*."

QMB Plus Medicaid: Participants who are covered by **both** QMB and another unrestricted Medicaid program (dually eligible), are entitled to full Medicaid benefits, which include eye exams and contract-supplied glasses/contacts. MAVIS identifies participants who have both QMB and Medicaid with this comment: "Medicaid Benefits for" a specific date of service, and "*Additional Coverage for Medicare Paid*

Services". For Medicaid reimbursement, all frames, lenses, or contacts must be ordered from the Idaho Medicaid vision-products Contractor.

Participants who are covered by a Medicare-Medicaid Coordinated Plan (MMCP) are dually eligible with Medicare and Medicaid, and have chosen a Medicare Advantage Insurance Plan. These participants do not have benefits for vision services under Medicaid fee-for-service. MAVIS identifies this coverage under Third Party Information with a coverage code **50** and the organization name, MMCP next to the carrier name. Contact the participant's specific insurance carrier for vision benefits.

3.1.5 Third Party Insurance

See *Section 2.4 Third Party Recovery (TPR)* in the General Billing Information Handbook regarding Medicaid policy on billing all other third party resources before submitting claims to Medicaid.

3.1.5.1 Third Party Insurance Verification

If after verification of third party information it is found that the coverage information is not correct, notify Idaho Medicaid's TPR Contractor, HMS, at: **(800) 873-5875** or fax to: **(208) 375-1134**. HMS will verify information and update the TPR file, if necessary. Medicaid coverage codes do not distinguish between eye exams and glasses/contacts. If only eye exams are a benefit, an Explanation of Benefits (EOB) is still required showing glasses/contacts are not covered.

3.1.5.2 Third Party Insurance Billing

Idaho Medicaid covers frames, lenses, and contacts only when provided by the Medicaid Contractor. Medicaid is the payer of last resort. If a Medicaid participant has other insurance for vision services; then the other insurance must be billed prior to billing Medicaid.

Some insurance companies utilize alternate providers of vision hardware. In those cases the participant must choose between the Medicaid product and the Non-Medicaid product. Medicaid reimbursement is dependent on the participant's choice of the following:

- The Medicaid contract product - there is no additional cost to the participant.
- A non-Medicaid contract product - the vision hardware is not reimbursable by Medicaid.

Providers may bill participants for the portion not covered by the non-Medicaid contract provider if the participant is informed prior to ordering. In those cases, the provider may wish to obtain a written agreement from the responsible party.

Other insurance companies do not specify where their members obtain their vision hardware. If the Medicaid participant has vision benefits from a third party insurance that does not specify a vision-product supplier, and the participant prefers to obtain their vision hardware from Medicaid's vision-products contractor, the following guidelines must be followed:

1. Provider places an order through Medicaid's vision-products contractor.
2. Contractor provides products ordered (frames and/or lenses) to the provider.
3. Contractor bills the provider for the products supplied at the same rate charged to Medicaid.
4. Provider bills the Third Party Insurance (TPI) for product and/or supplies.
5. Provider receives an explanation of benefits (EOB) and any payment from TPI.
6. Provider sends the EOB to the Contractor (regardless of whether or not any money was paid on the claim).
7. Contractor forwards the EOB to Medicaid.
8. Medicaid will reimburse Contractor for unpaid expenses not covered by TPI.
9. Contractor credits the amount received from Medicaid to the vision provider.

3.1.6 Place-of-Service (POS) Codes

All vision and optician services are processed with the following place of service code:

11 Office

3.1.7 Healthy Connections (HC)

Check eligibility to see if the participant is enrolled in HC, Idaho's Medicaid primary care case management (PCCM) model of managed care. If a participant is enrolled in the HC Program, there are certain guidelines that must be followed to ensure reimbursement for providing Medicaid-covered services. See *Section 1.5 Healthy Connections (HC)*, for more information.

Vision services performed in the offices of ophthalmologists and optometrists, including the dispensing of eyeglasses, do not require a HC referral. Procedures performed in an inpatient or outpatient hospital or ambulatory surgery center setting require a referral for the facility and ancillary physicians/providers such as anesthesiologists, pathologists, radiologists, pre-operative exam by a physician, and lab work. The HC referral must be obtained from the participant's primary care physician (PCP).

3.2 Vision Service Policy

3.2.1 Overview

Optical providers may bill Medicaid for the examination as well as a fitting/dispensing fee. Optical providers may also bill for repairs when repair guidelines are met.

All vision supplies (frames, lenses, contact lenses) must be ordered from the Medicaid Contractor, who will bill Medicaid for the supplies. Products obtained through any other lab can not be reimbursed by Medicaid.

Contractor contact information:

- **Call (800) 228-9732** for information on placing orders and obtaining a frame sample kit; or
- Fax orders to: **(800) 545-2693**; or.
- Mail eyeglass and contact lens orders to the following address:

  Barnett and Ramel Optical (B&R Optical)
  7154 N. 16th Street
  Omaha, NE 68112
  (800) 228-9732 (toll free)
  Fax: (800) 545-2693

Providers may view and order from the B&R Optical catalog online at: **http://broptical.com**.

3.2.2 Covered Services

The services listed in this section are covered by Idaho Medicaid. Eligible participants who have a diagnosed visual defect, and need eyeglasses to correct a refractive error, can receive eyeglasses within the guidelines defined in this section.

3.2.2.1 Comprehensive Vision Exams

Medicaid covers one complete visual examination annually (365 days) to determine the need for eyeglasses to correct a refractive error.

A comprehensive visual examination includes the following professional and technical vision services:

- History
- General medical observation
- External and ophthalmoscopic examinations
- Determination of best corrected visual acuity
- Gross visual fields
- Basic sensorimotor examination
- Refractive state
- Initiation of diagnostic and treatment programs.

Note: Initiation of diagnostic and treatment programs include:
- ✓ Prescription of medication
- ✓ Arranging for special ophthalmological diagnostic or treatment services
- ✓ Consultations
- ✓ Laboratory procedures
- ✓ Radiological services

Special ophthalmological services include interpretation and report by the physician/optometrists. Technical procedures (which may or may not be performed by the physician personally) are often part of the services but should not be mistaken to constitute the service itself.

Do not itemize service components such as:

- Slit lamp examination

- Keratometry
- Routine ophthalmoscopy
- Retinoscopy
- Refractometry
- Tonometry
- Biomicroscopy
- Examination with cycloplegia or mydriasis
- Motor evaluation

Idaho Medicaid reimbursement rate for the exam includes determination of refraction state.

Note: Idaho Medicaid requires the appropriate eye exam procedure code to be billed for eye exams. Evaluation and management procedures are paid only in the case of an eye injury or disease.

3.2.2.2 Lenses and Frames

Eligible participants who have been diagnosed with a visual defect, and need eyeglasses to correct a refractive error, can receive eyeglasses once every four years.

Contact Lenses: Contact lenses are covered when medically necessary criteria are met and services prior authorized by the Department.

Note: Medicaid will not pay for broken, lost, or missing frames or damaged or lost lenses.

3.2.2.3 Fitting Fee/Dispensing Fee

The dispensing provider may bill for fitting/dispensing when:

- The participant receives new frames or lenses (including contact lenses) that are reimbursed by Medicaid; and
- They are ordered from the Medicaid Contractor.

A fitting fee may be billed for replacement glasses if a notation of the valid replacement reason is indicated on the claim (i.e., major visual change).

3.2.2.4 Warranty

Repairs or replacement on glasses due to a defect in workmanship or materials are covered for 90 days by the Contractor.

3.2.2.5 Repairs

If repairs are needed after 90 days, the provider may bill Medicaid for the repairs using CPT code 92370. The Medicaid Contractor is not responsible for repairs outside the 90 day timeframe.

3.2.3 Limitations

This section outlines the limitations to vision services.

3.2.3.1 Prior Authorization (PA)

The products listed in the chart below require PA. PAs are valid for two (2) months from the date of authorization unless otherwise indicated on the approval. The PA number must be included on the contractor order form.

A copy of the Vision Prior Authorization Request form is available in the Forms Appendix D; Forms.

Fax requests to: **(208) 332-7280**

Mail requests to:

Division of Medicaid
Vision Services Prior Authorization
PO Box 83720
Boise, ID 83720-003

All vision products in the following table require PA by the Division of Medicaid.

Services Requiring PA	Criteria for Coverage
Aspheric lenses	Plus 8.00 diopter reading or greater
Contact lenses	Medically necessary contact lenses are covered for the following conditions: • Correction of Myopic condition equal to or greater than a minus 4.00 diopter in either eye • Cataract surgery • Keratoconus • Other medical condition (as defined by the Department) precludes the use of conventional lenses. **Note:** • Contact lenses billed for the same year as regular lenses are not payable by Medicaid. • Contacts are not covered for cosmetic or convenience purposes. • Fitting fees for contacts can only be billed to Medicaid if criteria are met for purchase of contacts.
Exams more frequent than 365 days	• Documented visual correction equal to or greater than plus or minus .50 diopter per eye. • The Exam is medically necessary.
Frames (more often than every four years)	Major change in visual acuity that cannot be accommodated by lenses that fit in the existing frame. **Note:** When frames not supplied by Medicaid, the participant is responsible for the cost of shipping to the Contractor if lens replacements are needed.
Specialty Frames	Frames such as those designed for infants or for children and adults with special needs (**V2025**) may be covered if prior authorized. Frames must be fully described and include justification of medical necessity.
Index lenses	Minus 4.00 diopter reading or higher - (**V2782 or V2783**).
Lenses more frequent than 365 days	• Documented visual correction change equal to or greater than plus or minus .50 diopter in one eye or the other - not a combined total for both eyes, or • A major add-on such as bifocals.
Lenticular or Myodisc	Equal to or greater than plus or minus 10 diopters.
Miscellaneous procedure codes	All miscellaneous procedure codes require PA.

Tints	• Diagnosis of albinism. • Other extreme medical conditions as defined by DHW. Tinted lenses are only payable when medically necessary and prior authorized by DHW. Tinted lenses for any other reason including cosmetic or convenience reasons are not covered by Medicaid.

Participants who desire additional features, that are not covered by Medicaid, may pay for them separately. The Medicaid contractor will bill the provider separately; and the provider may bill their usual and customary charge to the participant. If the participant cannot adapt to their new lenses that were not originally covered by Medicaid, the participant is responsible for any additional charges.

3.2.3.2 Refraction Procedures

Medicaid's reimbursement rate for exams includes determination of refractive state. If it is necessary to determine refractive state before 365 days have passed, providers may bill for refraction using procedure code **92015**. Additional exams and refraction procedures must be prior authorized. Determination of refractive state includes specification of lens type, lens power, axis, prism, absorptive factor, impact resistance, and other factors.

3.2.4 EPSDT Services Available For Participants Up To Age 21

Services identified as a result of Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) and which are currently covered by Idaho Medicaid will not be subject to the existing amount, scope, and duration, but may require prior authorization. The medical necessity for the additional service must be documented.

Prior Authorization is not required for repair or replacement of lost glasses, broken or outgrown frames, or damaged or lost lenses for participants under the age of 21 unless the original frame or lenses required a PA.

If medically necessary, frames are covered once every 365 days for participants under the age of 21. Frames will not be replaced unless criteria for replacement are met. Follow directions for obtaining a PA in *Section 3.2.3.1 Prior Authorization (PA)*. Providers must note the reason for the replacement of frames or lenses on the PA request form and the contractor's order form. The contractor must include this information when billing Medicaid.

3.2.5 Exclusions

The following services are not covered by Idaho Medicaid:

- Eye exercise therapy
- Trifocal lenses
- Progressive lenses
- Photo gray lenses
- Tints (unless there is a diagnosis of albinism or other extreme condition as defined by the Department)
- Services that are not medically necessary

As noted above, trifocal and progressive lenses are not covered; however, Medicaid will pay for the bifocal portion of the lenses. A participant who desires trifocal or progressive prescription lenses may pay separately for the difference between the usual and customary charge for bifocal lenses and the usual and customary charges for trifocal or progressive lenses. The Contractor will bill the provider separately and the provider may bill the participant their usual and customary charge.

Medicaid does not cover any part of the cost of remaking lenses when a participant cannot adapt to progressive or trifocal lenses. If the participant is unable to adapt to these lenses, the participant will be responsible for the charges for new glasses. In order to bill the participant, the provider must have informed the participant of this policy prior to placing the order.

3.2.6 Procedure Codes

Bill vision services using the appropriate CPT or HCPCS codes as listed in the *Current Procedural Coding* books. See *Section 3.2.1 Overview*. Listed below are codes with specific Medicaid limitations and/or additional billing information.

Service	Code	Description and Limitations
Determination of Refractive State	**92015**	Allowed once every 365 days when a full exam is not necessary. Medicaid reimbursement rate for the full exam includes determination of refractive state.
Tonometry	**92100**	Tonometry is considered included within a comprehensive visual exam. If an additional separate tonometry is needed, Medicaid will allow one additional tonometry within the same 365 day period as the comprehensive exam. This limitation does not apply to participants receiving ongoing treatment for glaucoma.

Note: For eye examinations, Medicaid requires the appropriate eye exam procedure code to be billed. Evaluation and management procedures are paid only for an eye injury or disease.

3.3 Claim Billing

3.3.1 Which Claim Form to Use

Claims that do not require attachments may be billed electronically using PES software (provided by EDS at no cost) or other HIPAA compliant vendor software.

To submit electronic claims, use the HIPAA compliant 837 transaction.

To submit claims on paper, use original red CMS-1500 claim form.

Note: All claims must be received within one year (365 days) of the date of service.

3.3.2 Electronic Claims

For PES software billing questions, consult the *Provider Electronic Solutions (PES) Handbook*. Providers using vendor software or a clearinghouse should consult the user manual that comes with their software. See *Section 2 General Billing*, for more information.

3.3.2.1 Guidelines for Electronic Claims

Provider Number: In compliance with HIPAA and the National Provider Identifier (NPI) initiative beginning May 24, 2008, federal law requires the submission of the NPI number on all electronic 837 transactions. Idaho Medicaid recommends providers obtain and register one NPI for each Medicaid provider number currently in use. It is recommended that providers continue to send both their Idaho Medicaid provider number and their NPI number in the electronic 837 transaction. Electronic 837 claims will not be denied if the transaction is submitted with both the NPI and the Idaho Medicaid provider number.

Detail Lines: Idaho Medicaid allows up to 50 detail lines for electronic HIPAA 837 Professional transaction.

Referral Number: A referral number is required on an electronic HIPAA 837 Professional transaction when a participant is referred by another provider. Use the referring provider's 9-digit Medicaid provider number, unless the participant is a HC participant. For HC participants, enter the provider's 9-digit HC referral number.

Prior Authorization (PA) Numbers: Idaho Medicaid allows more than one PA number on an electronic HIPAA 837 Professional transaction. A PA number can be entered at the header or at each detail of the claim.

Modifiers: Up to four modifiers per detail are allowed on an electronic HIPAA 837 Professional transaction.

Diagnosis Codes: Idaho Medicaid allows up to eight diagnosis codes on an electronic HIPAA 837 Professional Claim.

National Drug Code (NDC) Information with HCPCS and CPT Codes: A corresponding NDC is required on the claim detail when medications billed with HCPCS codes are submitted. See *Section 3.18.6.3 of the Physician Guidelines, f*or more information.

Electronic Crossovers: Idaho Medicaid allows providers to submit electronic crossover claims for professional services.

3.3.3 Guidelines for Paper Claim Forms

For paper claims, use only original CMS-1500 claim forms to submit all claims to Idaho Medicaid. CMS-1500 claim forms are available from local form suppliers.

All dates must include the month, day, century, and year.

Example: July 4, 2007 is entered as 07042007.

3.3.3.1 How to Complete the Paper Claim Form

The following will speed processing of paper claims:

- Complete all required areas of the claim form.
- Print legibly using black ink or use a typewriter.
- When using a printer, make sure the form is lined up correctly so it prints evenly in the appropriate field.
- Keep claim form clean. Use correction tape to cover errors.
- Enter all dates using the month, day, century, and year (MMDDCCYY) format. Note that in field 24A (From and To Dates of Service) there are smaller spaces for entering the century and year. Refer to specific instructions for field 24A.
- You can bill with a date span (From and To Dates of Service) only if the service was provided every consecutive day within the span.
- A maximum of six line items per claim can be accepted. If the number of services performed exceeds six lines, prepare a new claim form and complete all the required elements. Total each claim separately.
- Be sure to sign the form in the correct field. Claims will be returned that are not signed unless EDS has a signature on file.
- Do not use staples or paperclips for attachments. Stack the attachments behind the claim.
- Do not fold the claim form(s). Mail flat in a large envelope (recommend 9 x 12).
- Only one PA number is allowed for paper claims.
- When billing medications with HCPCS/CPT codes, an NDC or NDC Detail Attachment must be filled out and sent with the claim.

3.3.3.2 Where to Mail the Paper Claim Form

Send completed claim forms to:

EDS
PO Box 23
Boise, ID 83707

3.3.3.3 Completing Specific Fields of CMS-1500

Consult the Use column to determine if information in any particular field is required. Only fields that are required for billing the Idaho Medicaid Program are shown on the following table. Claim processing will be interrupted when required information is not entered into a required field.

The following numbered items correspond to the CMS-1500 claim form.

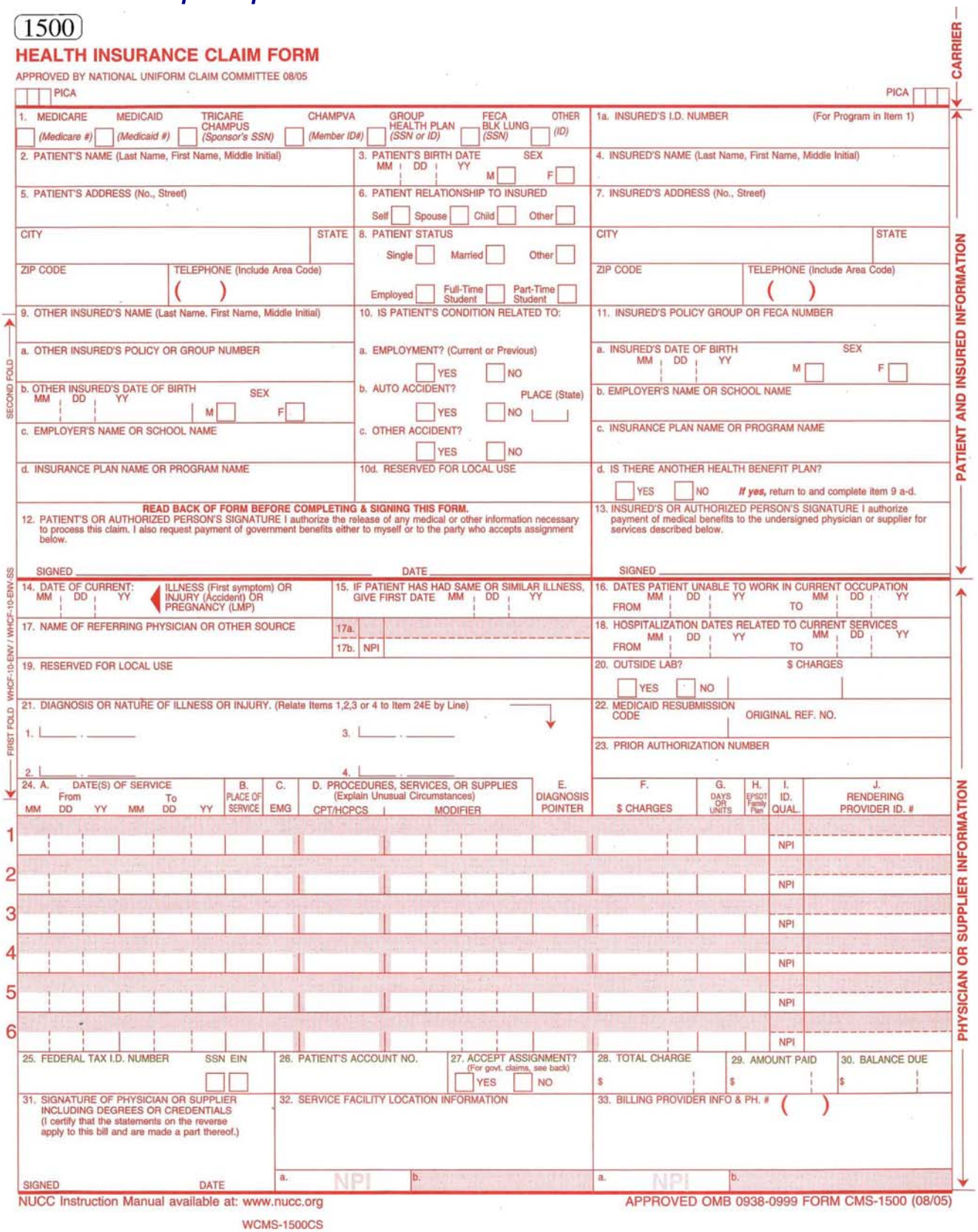
Field	Field Name	Use	Directions
1a	Insured's ID Number	Required	Enter the participant's 7-digit Medicaid identification (MID) number exactly as it appears on the MAID card.
2	Patient's Name (Last Name, First Name, Middle Initial)	Required	Enter the participant's name exactly as it is spelled on the MAID card. Be sure to enter the last name first, followed by the first name, and middle initial.
9a	Other Insured's Policy or Group Number	Required, if applicable	Required if field **11d** is marked yes. If the participant is covered by another health insurance or medical resource, enter the policy number.

Field	Field Name	Use	Directions
9b	Other Insured's Date of Birth/Sex	Required, if applicable	Required if field **11d** is marked yes. If the participant is covered by another health insurance or medical resource, enter the date of birth and sex.
9c	Employer's Name or School Name	Required, if applicable	Required if field **11d** is marked yes.
9d	Insurance Plan Name or Program Name	Required, if applicable	Required if field **11d** is marked yes. If the participant is covered by another health insurance or medical resource, enter the plan name or program name.
10a	Is Patient Condition Related to Employment?	Required	Indicate Yes or No, if this condition is related to the participant's employment.
10b	Is Patient Condition Related to Auto Accident?	Required	Indicate Yes or No, if this condition is related to an auto accident.
10c	Is Patient Condition Related to Other Accident?	Required	Indicate Yes or No, if this condition is related to an accident.
11d	Is There Another Health Benefit Plan?	Required	Check Yes or No, if there is another health benefit plan. If yes, return to and complete items **9a** - **9d**.
14	Date of Current: Illness, Injury, or Pregnancy	Desired	Enter the date the illness or injury first occurred, or the date of the last menstrual period (LMP) for pregnancy.
15	If Patient Has Had Same or Similar Illness/Give first Date	Desired	If yes, give first date, include the century. For pregnancy, enter date of first prenatal visit.
17	Name of Referring Physician or Other Source	Required, if applicable	Use this field when billing for a consultation or HC participant. Enter the referring physician's name.
17a	Blank Field	Required, if applicable	Use this field when billing for consultations or HC participants. For consultations enter the qualifier **1D** followed by the referring physician's 9-digit Idaho Medicaid provider number. For HC participants, enter the qualifier **1D** followed by the 9-digit HC referral number. **Note**: The HC referral number is not required on Medicare crossover claims.
17b	NPI	Not required	Enter the referring provider's 10-digit NPI number. **Note:** The NPI number, sent on paper claims, will not be used for claims processing.
19	Reserved for Local Use	Required, if applicable	If applicable, all requested comments for claim submission should be entered in this field. For example, enter injury information, including how, when, and where the injury occurred if another party is liable. This field can also be used to enter the ICN of previous claims to establish timely filing.
21 (1 - 4)	Diagnosis or Nature of Illness or Injury	Required	Enter the appropriate ICD-9-CM code (up to four) for the primary diagnosis and, if applicable, second, third, and fourth diagnosis. Enter a brief description of the ICD-9-CM primary and, if applicable, second, third, and fourth diagnosis.
23	Prior Authorization Number	Required	If applicable, enter the PA number from Medicaid, DHW, RMS, ACCESS, RMHA, QIO, or MT.

Field	Field Name	Use	Directions
24A	Dates of Service — From/To	Required	Fill in the date(s) the service was provided, using the following format: MMDDCCYY (month, day, century, and year). Example: November 24, 2003 becomes 11242003 with no spaces and no slashes.
24B	Place of Service	Required	Enter the appropriate numeric code in the place of service box on the claim.
24C	EMG	Required, if applicable	If the services performed are related to an emergency, mark this field with an X.
24D 1	Procedures, Services, or Supplies CPT/HCPCS	Required	Enter the appropriate 5-character CPT or HCPCS procedure code to identify the service provided.
24D 2	Procedures, Services, or Supplies Modifier	Desired	If applicable, add the appropriate CPT or HCPCS modifier(s). Enter as many as four. Otherwise, leave this section blank.
24E	Diagnosis Pointer	Required	Use the number of the subfield (1 - 4) for the diagnosis code entered in field **21**.
24F	$ Charges	Required	Enter the usual and customary fee for each line item or service. Do not include tax.
24G	Days or Units	Required	Enter the quantity or number of units of the service provided.
24H	EPSDT Family Plan	Required, if applicable	Not required unless applicable. If the services performed constitute an EPSDT program screen; see *Section 1.6 EPSDT*, for more information.
24I	ID. Qual.	Required, if Legacy ID	Enter qualifier **1D** followed by the 9-digit Idaho Medicaid provider number in **24J**.
24J	Rendering Provider ID #	Required, if applicable	Enter the 9-digit Idaho Medicaid provider number in the shaded portion of this field if the **1D** qualifier was entered in **24I**. **Note:** If the billing provider number is a group, then paper claims require the 9-digit Idaho Medicaid provider number of the performing provider in the Rendering Provider ID # field. **Note:** Taxonomy codes and NPI numbers, sent on paper claims, will not be used for claims processing.
28	Total Charge	Required	The total charge entered should be equal to all of the charges for each detail line.
29	Amount Paid	Required	Enter any amount paid by other liable parties or health insurance including Medicare. Attach documentation from an insurance company showing payment or denial to the claim.
30	Balance Due	Required	Balance due should be the difference between the total charges minus any amount entered in the amount paid field.
31	Signature of Physician or Supplier Including Degrees or Credentials	Required	The provider or the provider's authorized agent must sign and date all claims. If the provider does not wish to sign or signature stamp each individual claim form, a statement of certification must be on file at EDS. See *Section 1.1.4 Signature-on-File Form*, for more information.
33	Billing Provider Info & Ph. #	Required	Enter the name and address exactly as it appears on the provider enrollment acceptance letter or Remittance Advice (RA). **Note:** If you have had a change of address or ownership, immediately notify Provider Enrollment, in writing, so that the provider master file can be updated.

Field	Field Name	Use	Directions
33A	NPI	Desired, but not required	Enter the 10-digit NPI number of the billing provider. **Note:** NPI numbers, sent on paper claims are optional and will not be used for claims processing.
33B	Blank Field	Required	Enter the qualifier **1D** followed by the provider's 9-digit Idaho Medicaid provider number. **Note:** All paper claims will require the 9-digit Idaho Medicaid provider number for successful claims processing.

3.3.3.4 Sample Paper Claim Form



1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE TELEPHONE (Include Area Code)

ZIP CODE TELEPHONE (Include Area Code)

9. OTHER INSURED'S NAME (Last Name. First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes,* return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate Items 1,2,3 or 4 to Item 24E by Line)

1. 3.

2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1								NPI	
2								NPI	
3								NPI	
4								NPI	
5								NPI	
6								NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH. # ( )

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB 0938-0999 FORM CMS-1500 (08/05)

WCMS-1500CS

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SECOND FOLD

FIRST FOLD WHCF-10-ENV / WHCF-10-ENV-SS